STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 85642-001**

v

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 28th day of December 2007
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On October 8, 2007, XXXXX, authorized representative of XXXXX, (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The request was accepted on October 15, 2007.

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information it used in making its adverse determination. The Office of Financial and Insurance Services received BCBSM's response on October 24, 2007.

The issue in this external review can be decided by analyzing the contract affecting the Petitioner's health coverage. The contract is the BCBSM Community Blue Group Benefits Certificate (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). A medical opinion from an independent review organization was not required.

II
FACTUAL BACKGROUND

The Petitioner was treated in XXXXX from April 12, 2007 to June 30, 2007. The amount charged for this care was $88,716.62. XXXXX is a nonparticipating end stage renal disease (ESRD) facility. BCBSM denied payment for the Petitioner's care at XXXXX because this facility does not participate with any Blue Cross plan.

The Petitioner appealed BCBSM's denial. BCBSM held a managerial-level conference on September 18, 2007, and issued a final adverse determination dated September 21, 2007, confirming the denial of coverage.

III
ISSUE

Did BCBSM correctly deny coverage for the dialysis services provided the Petitioner at XXXXX?

IV
ANALYSIS

Petitioner's Argument

The Petitioner was receiving treatment at a participating facility as a peritoneal dialysis patient. Her physical and mental conditions were deteriorating. She consulted with her nephrologists and was admitted to XXXXX as a hemodialysis patient. She thrived under this treatment and was then able to have a successful kidney transplant.

XXXXX believes that BCBSM should pay for the Petitioner's dialysis care regardless of its participating status since it clearly benefited the Petitioner. It asks that the Petitioner's extenuating circumstances be considered and the decision should be based on what is best for the Petitioner's well being and quality of life.

The Petitioner's authorized representative indicated that XXXXX was contacted and asked to participate with Blue Cross Blue Shield on this case. The facility was not willing to do this.

The Petitioner believes that her care at XXXXX was medically necessary and it is unfair that BCBSM will not pay for it. She would like BCBSM to pay for these services.

BCBSM's Argument

BCBSM says that the certificate clearly provides (on page 3.32): "We pay for medically necessary facility services provided by a BCBSM **participating** end stage renal (kidney) disease facility." XXXXX is not a participating facility (i.e., has not signed a participation agreement with BCBSM or a local Blue Cross and Blue Shield plan agreeing to accept either organization's approved amount as payment in full). For that reason, the facility charges associated with the Petitioner's dialysis treatment from April 12, 2007 until June 30, 2007 are not a covered benefit.

BCBSM also argues that there is no provision in the certificate that allows an exception for a nonparticipating ESRD facility's charges to be paid by BCBSM. Moreover, the fact that XXXXX provided the Petitioner with medically necessary care also does not obligate BCBSM to pay the facility fees. BCBSM says that it is required to administer benefits for its members according to the terms of their coverage and therefore it is unable to assume responsibility for the dialysis charges incurred by the Petitioner.

Commissioner's Review

It is undisputed that XXXXX is a nonparticipating facility. Regarding nonparticipating facilities, Section 3 of the certificate, *Coverage for Hospital, Facility and Alternatives to Hospital Care*, not only says that BCBSM pays for "medically necessary facility services provided by a BCBSM participating end stage renal (kidney) disease facility," it also states on page 3.33:

> **Services That Are Not Payable**
> - Services provided by a **nonparticipating** end stage renal disease facility.

The Commissioner concludes that the facility services for the Petitioner's care from April 12, 2007 until June 30, 2007 are not a covered benefit because XXXXX is a nonparticipating

end stage renal disease facility. While the Commissioner understands that the Petitioner believes she received needed care at XXXXX and is sympathetic to her position, the Commissioner is limited in PRIRA reviews to determining whether an insurer has correctly applied the terms of the policy. In this case, BCBSM has correctly applied its policy to the Petitioner's claims.

V
ORDER

Respondent BCBSM's final adverse determination of September 21, 2007, is upheld. BCBSM is not required to pay the facility charge for XXXXX from April 12, 2007 through June 30, 2007, since it is not covered under the certificate.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.